Your summary of benefits

Anthem

Anthem® BlueCross and BlueShield

Your Plan: Anthem Blue Access Choice PPO HSA-City of St Louis HDHP Plan

Your Network: Blue Access Choice

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$3,000 person / $6,000 family	$9,000 person / $18,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$4,000 person / $6,850 family	$10,000 person / $20,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care Visit	10% coinsurance after deductible is met	40% coinsurance after deductible is met

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Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	10% coinsurance after deductible is met	40% coinsurance after deductible is met
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy *Coverage has unlimited visits per benefit period. Applies to In-Network and Out of Network. Limit is combined across professional visits and outpatient facilities.*	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met

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Diagnostic Services		
Lab:		
Office	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray:		
Office	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	40% coinsurance after deductible is met

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Emergency and Urgent Care		
Urgent Care *The urgent care office visit cost share applies to both office and facility based urgent care providers.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	10% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air, Ground, and Water) *Non-emergency non-network Ambulance Services are unlimited.*	10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Facility visit:		
Facility Fees	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	10% coinsurance after deductible is met	40% coinsurance after deductible is met

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Doctor and Other Services:		
Hospital	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Skilled Nursing is limited to 100 days, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 60 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Human Organ and Tissue Transplants *Acquisition and transplant procedures, collection and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	10% coinsurance after deductible is met	40% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage has unlimited per benefit period. In-Network and Non-Network combined. Private Duty Nursing limited to 82 visits/Calendar Year and 164 visits/lifetime. In-Network and Non-Network combined.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation and Manipulation Therapy services is limited to 20 visits per benefit period. Limit does not apply to manipulation performed by a Chiropractor. Limit is combined In-network and Non-Network across professional and outpatient visits. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation and Manipulation Therapy services is limited to 20 visits per benefit period. Limit does not apply to manipulation performed by a Chiropractor. Limit is combined In-network and Non-Network across professional and outpatient visits. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met

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Pulmonary rehabilitation		
Office *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for Skilled Nursing is limited to 100 days, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 60 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs after cancer treatment is limited to 1 item per benefit period. Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network. Applies to In-Network.*	10% coinsurance after deductible is met	40% coinsurance after deductible is met

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Notes:

- The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums commingle and accumulate toward each other.
- Dependent age: to end of the month in which the child attains age 26.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- If office visit is a coinsurance, the coinsurance also applies to allergy injections.
- Certain diabetic and asthmatic supplies are covered subject to applicable prescription drug copayments/coinsurance when you get them from an In network pharmacy. These supplies are covered as medical supplies and durable medical equipment if you get them from an Out of network pharmacy. Diabetic test strips are covered subject to applicable prescription drug copayment/coinsurance. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- DME - 10%/40% coinsurance for Network/Non-Network Durable Medical Equipment, Medical Supplies, Orthotics, Asthma Supplies, and Phenylketonuria (PKU). Excludes Prosthetics, Wigs, Diabetic Supplies and Mastectomy prostheses which will apply the plan's cost shares.
- Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice. Specialist (SCP) copayment is applicable to all Specialists (excludes: General Physicians, Internists, Pediatricians, OB/Gyns, Geriatrics, Physical Therapy, Occupational Therapy or any other Network provider as allowed by the plan).
- Immunization through age 5 – No Cost Share up to the maximum allowable amount (Network/Non-Network).
- Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.

Questions: (833) 578-4436 or visit us at www.anthem.com

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- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.
- Private Duty Nursing- limited to 82 visits/Calendar Year and 164 visits/lifetime.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 578-4436

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4436 .

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Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 578-4436。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 578-4436 تماس بگیرید.

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Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 578-4436.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 578-4436.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(833) 578-4436 にお電話ください。

Language Access Services:

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 578-4436로 문의하십시오.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídíłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h íłínígóó. Ataʼ halneʼígíí łaʼ bichʼįʼ hadeesdzih nínízingo koji̯ʼ hodíílnih (833) 578-4436.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 578-4436.

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Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 578-4436.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 578-4436.

It's important we treat you fairly
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